



# Dear Minister, please save yourself from activity-based funding

Fragmented funding, governance and delivery remain major obstacles to health care reform for sustainability

Reforms undertaken by recent Australian governments have their origin in the 2007 federal election campaign. Then Prime Minister John Howard focused the campaign on hospital funding, as an example of poor state governance, by promising to directly fund the Mersey Hospital near Devonport in Tasmania. The newspapers captured the spirit of the move with the headline “PM goads states with hospital takeover”.<sup>1</sup> Then opposition leader Kevin Rudd soon countered with his own plan, reported in the press as the “Health buck stops here”.<sup>2</sup> As Prime Minister, Kevin Rudd tried valiantly to implement direct federal control of hospitals by linking it to significant funding increases. However, the states, at the decisive April 2010 Council of Australian Governments meeting, won the political battle — they took the money, but rejected direct federal control.<sup>3</sup> Not to be completely outmanoeuvred, the federal government did manage to implement a number of centralised control mechanisms, including the National Health Performance Authority and the Australian Commission on Safety and Quality in Health Care. The most intrusive, from the states’ perspective, is the Independent Hospital Pricing Authority (IHPA) whose “primary function is to calculate and deliver an annual National Efficient Price” for federal activity-based funding of state-run public hospital services (<http://www.ihpa.gov.au>).

This is the public hospital arrangement the new coalition government has inherited. Notwithstanding the challenges of vertical fiscal imbalance, the states have insisted on retaining control of public hospitals, while the federal government has increased its control through these national structures. Moving forward, the federal government will need to decide what approach it will take to its relationship with the states on this matter — will it seek a policy of “dual federalism”, in which the federal government will have more power than the states, or will it encourage “new federalism”, with more power devolved to the states?

This choice will be tested by the government’s approach to activity-based funding. Activity-based funding is a piece of managerial rationalism that seeks to distil the vast and diverse range of hospital activities such as inpatient, outpatient, emergency and subacute care and some inpatient substitution into a single dollar value. This “national efficient price” (NEP), expressed as the “national weighted activity unit”, in the 2013–14 financial year is \$4993.<sup>4</sup> While acknowledging the rigour and transparency of IHPA’s work in developing the NEP, it is an artifice that can best be seen as a tool. The question is, how will the tool be used?



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doi: 10.5694/mja13.00254

Using it as a funding mechanism, the federal government will be at risk of growth in demand for hospital services. It will also face a barrage of lobbying and political activity about the complex elements of the relative weighting of hospital and substitution activities, their costing and the pricing rules, and about which activities are in scope (and hence cost-shared with the federal government) and which are not. Each state will have its own story to tell as their health systems vary in structure and practice, including in the ratio of private to public beds, primary care systems, subacute care and the sophistication of hospital substitution. Innovation is stifled in such a funding model, and confusion is increased about the respective roles of the federal and state governments.

A lesson of the past 7 years is that the states want to continue to play the dominant role in providing public hospital services and have the clout to achieve this objective. To be effective, they need to transcend their focus on “controlling public hospitals” to becoming more sophisticated and nuanced purchasers, encouraging quality outcomes and innovations to enhance productivity. The federal government can help by moving away from its activity-based funding model for public hospitals to less intrusive population funding, adjusted for health care risks associated with age, sex, chronic disease, and socioeconomic determinants including remoteness and Aboriginality. This would reduce complexity, clarify the role of the federal government as a funder with a focus on health outcomes rather than on the detailed cost of hospital processes, and leave the states to run the public hospital system with a clear incentive for efficiency. It might well pave the way for further transfer of federal health funding to the states, like in Canada, and provide the basis for the gradual evolution to a consumer-controlled, but tax-funded, health system<sup>5</sup> that we know as Medicare Select.<sup>6</sup>

**Competing interests:** No relevant disclosures.

**Provenance:** Not commissioned; not externally peer reviewed.

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- 6 Boxall A. What is Medicare Select? Canberra: Parliament of Australia, 2009. [http://www.aph.gov.au/About\\_Parliament/Parliamentary\\_Departments/Parliamentary\\_Library/pubs/BN/-/link.aspx?\\_id=1A40368E68EF41929953AD58EE3746C1&\\_z=z](http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/-/link.aspx?_id=1A40368E68EF41929953AD58EE3746C1&_z=z) (accessed Feb 2014).